Inspection Report

University Of Utah
Office Of Comparative Medicine
75 South 2000 East, Suite 311
Salt Lake City, UT 84112

Customer ID: **12**
Certificate: **87-R-0001**
Site: 003
UNIVERSITY OF UTAH

Type: ROUTINE INSPECTION
Date: Apr-26-2016

2.32 (a)

PERSONNEL QUALIFICATIONS.

In August 2015, a cynomolgus macaque placed under anesthesia for a study procedure was observed to have a low body temperature. In order to normalize the animal's core temperature during the procedure, a staff member was directed by a veterinarian to use a hot air source; however, the nozzle of this hot air source was inappropriately placed in a location which subsequently led to thermal injuries and later, euthanasia.

It is the responsibility of the research facility to ensure that all scientists, research technicians, animal technicians, and other personnel involved in animal care, treatment, and use are qualified to perform necessary or directed duties. This responsibility shall be fulfilled in part through the provision of training and appropriate instruction to those personnel.

Corrective measures were taken, including but not limited to, retraining of all involved staff and observation of techniques by veterinary staff.

This item has been corrected by the facility.

2.33 (b) (2)

ATTENDING VETERINARIAN AND ADEQUATE VETERINARY CARE.

Review of facility records for a cynomolgus macaque which was euthanized in August 2015 due to complications resulting from an approved procedure indicate that the animal did not receive adequate veterinary care during this procedure.
According to anesthesia records, there was a period of over 30 minutes in which no temperature was recorded while the animal was under anesthesia for this procedure. This is contrary to the approved protocol which states that a rectal temperature will be continuously monitored under anesthesia. By monitoring the temperature at more frequent intervals, changes in temperature may be identified and addressed sooner. Records indicate that the warming blanket used to maintain body temperature during anesthesia had not been turned on by the veterinary team. Subsequently, the veterinarian authorized the use of a hot air source in an attempt to raise the animal 's body temperature; however the source was

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inappropriately placed by a staff member and led to thermal injuries to the animal.

A review of this adverse event indicates that although a clinical veterinarian was present during the procedure, there was a failure of appropriate communication and oversight. The result led to the inappropriate placement of a hot air source by an individual staff member and subsequent animal injury severe enough that euthanasia was warranted.

Failure to provide animals with appropriate methods of veterinary care and oversight during approved procedures may cause unnecessary pain and distress to the animal.

Each research facility shall establish and maintain programs of adequate veterinary care that include the availability and use of appropriate methods to prevent, control, diagnose, and treat diseases and injuries to the animals.

The research facility acted promptly to address this incident by conducting a thorough investigation, self-reporting the incident, and swiftly implementing appropriate corrective actions to prevent future occurrences. Corrective actions provided retraining of all personnel involved in the procedure including monitoring associated with this protocol.

This item has been corrected by the facility.

This inspection was conducted on 04/26/2016 and 04/27/2016.

Exit interview was conducted with a facility representative.

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